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Medicare

Provider Reimbursement Manual

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CHECK SHEET OF PROVIDER REIMBURSEMENT MANUAL TRANSMITTALS
PART II, CHAPTER I

This Check Sheet should be placed immediately in front of Chapter 1 to provide a record of manual revisions received. These revisions will be issued under cover of consecutively numbered transmittals.

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1.	6/78	16.		31.		46.	
2.	1/79	17.		32.		47.	
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4.	9-80	19.		34.		49.	
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CHAPTER 1

COST REPORTING

FOR INTERIM MANUAL INSTRUCTIONS

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100. REQUIREMENT TO FILE COST REPORTS

Providers of service participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries [42 U.S.C. 1395g (section 1815(a) of the Social Security Act]. Regulations state that cost reports "will be required from providers on an annual basis...." [42 C.F.R. 405.406(b)]. When a provider fails to file a timely cost report, all interim payments since the beginning of the cost reporting period can be deemed overpayments. (See Part I, § 2413.)

102. COST REPORTING PERIOD

For cost reporting purposes, Medicare requires submission of annual reports covering a 12-month period of operations based upon the provider's accounting year.

The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the intermediary approves a change in the provider's reporting period.

A cost reporting period under the program consisting of one of the following will be considered in compliance with the reporting periods cited above:

A. Twelve (12) successive calendar months

B. Thirteen (13) four-week periods with an additional day (two in leap year) added to the last week or period to make it coincide with the end of the calendar year or month,

C. A reporting period which will vary from 52 to 53 weeks because it must always end on the same day of the week (Monday, Tuesday, etc.) and always end on (1) whatever date this same day of the week last occurs in a calendar month, or (2) whatever date this same day of the week falls which is nearest to the last day of the calendar month, even though this same day falls in the first week of the following month. A new provider beginning operations on January 1, 1974, and entering the program as of that date, could choose a reporting period beginning with that date and ending, for example, Wednesday, December 25, 1974. This provider's accounting period would end on the same day of the week (Wednesday) and on whatever date that day of the week last occurs in the final month of the year. Alternatively, the provider could elect to end its first reporting period on January 1, 1975; this would be based on the election to end the period on the same day of the week which is nearest to the last day of the calendar year, even though the last day falls in the first week of the following month. The method selected must be consistently followed.

A provider may prepare a short period cost report for part of a year under the circumstances described in §§ 102.1 through 102.3.

Where a provider did not furnish any covered services to Medicare beneficiaries or where it had low utilization of such services in a reporting period, a full cost report need not be filed. See § 110 for an explanation of this procedure.

Providers in a chain organization, or other group of providers, are required to file individual cost reports as explained in § 112.

102.1 Initial Cost Reporting Period.--In order to conform its initial Medicare cost reporting period to the annual reporting period it wishes to use, a provider may be permitted or required under the circumstances outlined below, to file its first Medicare cost report covering less than or more than a year (as defined below) of provider operations. The ending date (or day) chosen by the provider for its initial reporting period is presumed to be the ending date (or day) the provider elects for its subsequent annual reporting periods.

In the case of a newly constructed provider that enters the Medicare program during its initial business year, and in the case of providers that re-enter the Medicare program after a change of ownership, provider operations are considered to commence for cost reporting purposes when the first patient is admitted as an inpatient or receives outpatient services (hospital or SNF), when the first visit is rendered (home health agency), or when the first physical therapy or speech pathology service is rendered (rehabilitation agency, clinic, public health agency). Therefore, a provider's initial cost reporting period may not start before the beginning of the month in which it first renders patient care services which could be covered under the program.

A. Established Providers.--A provider is considered to be an established provider upon its entry into the Medicare program if it was in operation at least one year prior to the effective date of its participation. An established provider may file its initial Medicare cost report covering a period of at least one month of provider operations under the program, but not to exceed 13 months of operations under the program.

If an established provider wished to report on a calendar year basis and entered the program on July 1, 1977, it could have filed its initial cost report for the period beginning January 1, 1977, and ending December 31, 1977, or alternatively, for the period beginning July 1, 1977, and ending December 31, 1977.

B. New Providers.--A provider (including a provider that changes ownership) is considered to be a new provider upon its entry into the program if it enters the program at the inception of or during its initial business year. A new provider may file its initial cost report covering a period of at least one month of provider operations under the program but not to exceed 13 months of operations under the program.

If the provider enters the program at the same time that it begins operations, the initial cost reporting period will begin with the effective date of participation. For example, a hospital that began operations and entered the program on September 15, 1976, and wished to adopt a reporting period ending date of September 30, must have filed its initial cost report covering the period from September 15, 1976, through September 30, 1977. It could not have filed the report for the 15-day period ending September 30, 1976.

If a new provider wished to report on a calendar year basis, began operations on February 1, 1977, and entered the program on July 1, 1977, it could have filed its initial cost report for the period beginning February 1, 1977, and ending December 31, 1977, or, alternatively, for the period beginning July 1, 1977, and ending December 31, 1977.

If the provider does not begin operations until after the effective date of its entry into the program, the initial reporting period will begin with the first day of the month in which patient care service begins. For example, a hospital which entered the program effective August 1, 1977, but did not begin delivering patient care services until September 15, 1977, and wished to adopt a reporting period ending date of September 30, could have filed its initial cost report covering a period beginning September 1, 1977, and ending on either September 30, 1977, or September 30, 1978.

102.2 Cessation of Participation in Program.--

A. General.-- When a provider ceases to participate in the health insurance program, it must file a cost report covering a period under the program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than 1 month or not more than 13 months.

B. Payment for Services After A Provider Ceases to Participate in the Program (Termination, Expiration, or Cancellation of the Provider Agreement)--

1. Hospital and SNF.--Effective October 30, 1972, a hospital or skilled nursing facility whose provider agreement either voluntarily or involuntarily ceases (not a change of provider ownership) may be reimbursed under the agreement for up to 30 days of covered Part A inpatient services furnished on or after the effective date of cessation of participation in the program to patients who are admitted before the cessation date. No payment will be made for such services to patients admitted on or after the cessation date.

No payment will be made for hospital services to outpatients or for outpatient physical therapy or speech pathology services furnished by a provider on or after the effective date of cessation. However, payment may be made under Part B to a nonparticipating provider for the medical and other health services which it furnishes in compliance with specified requirements explained in the Nonparticipating Domestic Hospital Supplement (HIM-30) of the Hospital Manual (HIM-10).

2. Home Health Agency.--Payment can continue to be made to home health agencies for covered Part A and Part B home health services furnished through the calendar year in which the cessation is effective where the plan of treatment was established prior to the date of cessation. No payment will be made for home health services furnished under a plan or treatment established on or after the cessation date.

3. Interim Rate.--Payment for allowable covered services after cessation of participation will be made at an interim rate not to exceed the interim rate developed on the basis of the latest cost report submitted by the provider. No adjustment should be made to this interim rate until the cost report ending with the date of cessation has been audited, unless the intermediary obtains information that would justify a change in the interim rate. Settlement for such services will be on the basis of a per diem rate developed from Medicare data appearing in the provider's final settled cost report ending with the date of cessation. No cost report will be required for the services furnished following cessation.

102.3 Changing of Cost Reporting Periods.--A provider must adhere to the cost reporting period initially selected unless a change has been authorized in writing by its intermediary. For the change to be effective, the provider's written request must be received by the intermediary 120 days or more before the close of the reporting period which the change proposes to establish. The intermediary should notify HCFA of the authorized change 30 days or more before the close of the reporting period which the change proposes to establish to allow the Administration sufficient time to adjust its records. For example, where a provider wishes to change the ending date of its cost reporting period from December 31 to July 31, the provider's request for a change must be received by the intermediary 120 days or more before the July 31 date on which the change is to take effect.

Such a change may be made only after the intermediary has established that the reason is consistent with the purposes and intent of the program. Under the foregoing circumstances, the provider may file a cost report for a period of not less than one month or not more than 13 months. A change which is made primarily to maximize reimbursement in any one period would not be acceptable.

Providers owned and/or operated by governmental entities using fiscal year ending dates established by local law, may require changes in the reporting year ending dates as a result of legislative action. In such situations, a provider with the approval of its intermediary may revise its cost reporting period to conform to the new fiscal year established by the applicable lawmaking body. A transitional period report covering the period initially affected by the change should be filed, provided it covers a period of not less than one month or more than 13 months.

104. COST REPORT DUE DATES

Cost reports are required to be filed following the close of a provider's reporting period. (See § 102). The due dates for cost reports are as follows:

A. Provider Continues to Participate in Program.—

1. Cost reports are due on or before the last day of the third month following the close of the period covered by the report.

2. A 30-day extension of the due date of a cost report may, for good cause, be granted by the program. To be granted this extension, the provider must submit a written request and obtain written approval from the servicing intermediary prior to its cost report due date.

An extension of the cost report due date may not be granted based on a pending review by the intermediary or the Health Care Financing Administration (HCFA) of a non-Medicare cost reporting form. The fact that a provider or a forms preparation service is awaiting the intermediary's or HCFA's review and determination of acceptability of a non-Medicare cost reporting form does not constitute good cause for granting an extension of the due date. In this situation, the provider must use the official Medicare cost reporting forms and file its cost report in accordance with § 104.A.1 above.

3. Where a hospital or hospital-based SNF or hospital-based HHA submits a certified cost report that has been audited by the independent auditors of the hospital, the cost reports are due on or before the last day of the fourth month following the close of the period covered by the report. Such provider should notify the intermediary in writing by the end of the cost reporting period if it intends to file a certified cost report.

B. Provider Agreement to Participate in Program Terminates (Voluntarily or Involuntarily) or Provider Experiences Change of Ownership.--

1. Cost reports are due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership.

2. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

106. COST REPORTING FORMS
Medicare issues standard forms for the preparation of provider cost reports:

FORM	USED BY
HCFA-2551	Hospitals and hospital-skilled nursing facility complexes having less than 100 beds and all skilled nursing facilities, other than all-inclusive rate and no charge structure providers. (See Chapter 2.)
HCFA-2552	Hospitals and hospital-skilled nursing facility complexes having more than 99 beds (See Chapter 3.)
HCFA-1728	Home Health Agencies (See Chapter 4.)
HCFA-1729	Provider-based Home Health Agencies (See Chapter 5.)
HCFA-2088	Outpatient Physical Therapy Providers (See Chapter 6.)

Cost reporting forms for all inclusive rate and no-charge structure providers are listed in Chapter 7.

108. USE OF SUBSTITUTE COST REPORTING FORMS
Substitute cost reporting forms may be accepted for use in lieu of the official HCFA forms. However, substitute cost reporting forms may not be used until they have been reviewed and accepted by the intermediary or HCFA as described below.

108.1 Conditions Under Which Substitutes for Medicare Cost Reporting Forms May Be Accepted for Use Without HCFA Approval.--

A. Since the format of substitute cost reporting forms must be identical to the official Medicare cost reporting forms, except where a change in format is necessary to accommodate a cost finding method which is more sophisticated than the step-down process, the following guidelines have been established under which the acceptability of certain substitute cost reporting forms can be determined by the intermediary without HCFA review.

1. The substitute cost reporting forms submitted to the intermediary for review will be limited to those which are generated and used by a single provider.

2. The provider is a hospital or hospital-skilled nursing facility complex using the Departmental RCCAC Method of Cost Apportionment.

3. The provider uses either the step-down method or the double apportionment method of cost finding.

4. The substitute cost reporting form or forms are substitute for one or more of the following Medicare cost reporting forms, and are appropriately identified by inserting the proper title on each worksheet.

a. Hospital and Hospital-Skilled Nursing Facility Complex Statistical Data.

Part I - General
Part II - Hospital Statistics
Part III - Other Hospital Data
Part IV - Subprovider and Skilled Nursing Facility Statistics
Part V - Other Subprovider and Skilled Nursing Facility Data

b. Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses

c. Worksheet B - Cost Allocation - General Service Costs and
Worksheet B-1 Cost Allocation - Statistical Basis

d. Worksheet C - Departmental Cost Distribution

e. Worksheet G - Balance Sheet
Worksheet G-1 - Statement of Changes in Fund Balances
Worksheet G-2 - Statement of Patient Revenues and Operating Expenses
Worksheet G-3 - Statement of Revenues and Expenses

5. All substitute cost reporting forms (other than forms substituted for Medicare cost reporting forms, Worksheets G, G-1, G-2, and G-3) must be identical in all respects to the HCFA forms, including designating by some distinctive symbol or character those areas which are shaded on the official Medicare worksheets, except that one or more of the following conditions may exist.

a. Additional columns and/or lines may be inserted within the present format for additional cost centers in accordance with the provider's accounting system; or

b. The allocation bases used on Worksheet B-1 may be identified on a separate form; or

c. Unit cost multipliers may be identified on a separate worksheet form Worksheet B-1; or

d. Under the double apportionment method, appropriate changes may be made to Worksheets B and B-1 to provide for the two separate cost allocations.

The changes which include additional lines and/or columns for more cost centers must be consistent with the provider's functional and departmental organization and the bases and order of allocation must be appropriate to properly allocate the costs to all departments where these costs apply.

6. With respect to HCFA forms, Worksheets G, G-1, G-2 and G-3, the provider may substitute its own financial statement for these worksheets, provided the information shown on such statements is at least as detailed as that requested on the HCFA forms.

108.2 Conditions Under Which Substitutes for Medicare Cost Reporting Forms Must Be Submitted to HCFA for Review.--

The following guidelines and requirements have been established for substitute cost reporting forms which must be submitted to HCFA for review.

A. Initial substitute cost report reviews

1. All substitutes for Medicare cost reporting forms which do not meet the conditions of approval cited in §108.1 and those which will be marketed on a regional or national level, must be sent directly to the Health Care Financing Administration rather than being submitted through the intermediary.

2. As a condition for acceptance of substitute cost reporting forms, organizations desiring approval will be required to prepare their substitute cost reporting forms using the cost reporting input data which has been developed by HCFA. This input data can be acquired by writing to:

Health Care Financing Administration
Division of Institutional Services Reimbursement
Bureau of Program Policy
Room 1-A-5 East Low Rise
Baltimore, Maryland 21235

3. The written request filed by the organizations must disclose the following.

a. The cost reporting situations for which substitutes would be prepared (hospital only, skilled nursing facility only, hospital-skilled nursing facility complex, proprietary hospital, etc.),

b. The cost finding method(s) to be used, and

c. The fiscal year for which cost reports would be prepared (approvals will be prospective only).

4. Hard copy input data necessary to prepare the types of cost reports designated will be sent by HCFA to the organization filing the request. Based on the input data, the organization will prepare designated cost report(s) and submit one (1) copy (copy must be original full-size print out) to HCFA for review. One (1) copy of the applicable Users Manual (written description of the standard and optional features of the computer program) and the completed input sheets must also be submitted along with the substitute cost reports.

5. The cost report submitted for review must be a complete cost report package. They must include completed cost reporting forms which are not being substitutes along with the substitute cost reporting forms using the input data provided by HCFA.

6. All substitute cost reporting forms (other than forms substituted for HCFA forms, Worksheets G, G-1, G-2 and G-3) which are computerized must comply with the following form requirements.

a. All line descriptions, line numbers, column descriptions and column numbers as shown on the official worksheets must be printed if used or not used with the following exceptions: (1) Calculation references do not need to be printed, (2) Transfer references to and from other worksheets do not need to be printed, (3) Shading will not be required to be printed, (4) Preprinted negatives are not needed but minus signs must be shown where applicable, (5) Percentage signs do not have to be printed, (6) Dollar signs do not have to be printed, (7) Spaces not used do not have to be filled with zeros or labeled "Blank" and (8) Abbreviations may be used where necessary due to printing space but abbreviations must be understandable and consistent throughout the substitute cost report.

b. The heading of the worksheet must include at least, (1) the name of the organization responsible for the substitute cost report system, (2) the worksheet title (i.e., "Reclassification and Adjustment of Trial Balance of Expenses - Worksheet A), (3) the statement, "In lieu of form HCFA-2552, Page No. _____" (the page number must be the page number of the official Medicare worksheet; e.g., page 13 for Worksheets A-8-1 and A-8-2, pages 14/15 for Worksheet B; and where the substitute is for a supplemental worksheet, the letter designation must follow the form number), (4) provider number, (5) period from and to and (6) date of computer run on each page.

c. Additional lines and/or columns not provided on the official worksheets may be added and need only to be printed when used. The changes which include additional lines and/or columns for more cost centers must be consistent with the provider's functional and departmental organization.

d. Worksheets which must be printed on more than one page because of space must show all the information as described in 6a through 6c. Also, the page number of the official worksheet must show "continued" after the page number.

e. With respect to HCFA forms, Worksheets G, G-1, G-2 and G-3, the provider may substitute its own financial statement for these worksheets, provided the information shown on such statements is at least as detailed as that requested on the HCFA forms.

f. There must be no printing on the print-out perforation and the print out must have at least a ½ inch border around the print out.

7. Appropriate changes must be made to Worksheets B and B-1 and Worksheet D-1, lines 25 and 26 to accommodate more sophisticated cost finding methods (i.e., Double Apportionment, Multiple Apportionment and Matrix). The cost finding method used must be identified on Worksheets B and B-1 and Worksheet D-1, lines 25 and 26. For every allocation, a separate Worksheet B and B-1 and Worksheet D-1, lines 25 and 26 must be printed (e.g., Double Apportionment - a separate Worksheet B and B-1, and D-1 must be printed for each allocation). Line descriptions, line numbers, column descriptions and column numbers must be shown on each worksheet. Specific guidelines on format changes for Double Apportionment, Multiple Apportionment and Matrix are detailed in section 108.3.

8. The organization will be notified in writing as to the acceptance or nonacceptance of the substitute cost reporting forms.

9. When the Health Care Financing Administration finds computerized substitute cost reporting forms to be acceptable for Medicare cost reporting purposes, such acceptance applies to the computer programs as well as the cost reporting forms which are generated by the computer programs. The organization which received the acceptance is responsible to insure that the substitute forms and computer programs remain identical to those which HCFA accepted for Medicare cost reporting purposes. Therefore, when computer programs are sold or leased by an organization which has previously obtained acceptance from HCFA, such acceptance and the responsibility for the integrity of the cost reporting system are not transferable to the vendee or lessee. A statement must be attached to the report disclosing whether the report was prepared using purchased or leased computer programs and the names and addresses of the vendor or lessor and the vendee or lessee. Any change to a computer program invalidates HCFA acceptance (i.e., providing additional substitute worksheets which were not previously reviewed and approved by HCFA for the official Medicare worksheets, providing for other cost finding methods which were not previously reviewed and approved by HCFA).

10. Substitutes for Medicare cost reporting forms that are used for title V and/or title XIX inpatient hospital services as well as for title XVIII services will be reviewed for acceptability by HCFA. Therefore, any substitute cost reporting form intended for use for title V and/or title XIX inpatient hospital services must contain all necessary worksheets pertaining to title V and/or title XIX. If these worksheets are not included, the review will be limited to title XVIII applications of the substitute cost reporting forms.

11. Before any computerized system can be considered for intermediary use, the system must first be reviewed and accepted by HCFA for provider use.

B. Ongoing followup reviews

1. At irregular intervals, HCFA may test any substitute cost reporting system. Without previous announcement, HCFA will send input data necessary to prepare Medicare cost reports to organizations with existing approvals. Such organizations will be subject to followup reviews either individually or in groups.

2. An organization will be given sixty (60) days to submit a completed cost report using the input data provided by HCFA.

3. If the substitute cost report is not received within sixty (60) days, the approval of that organization's substitute cost report will be suspended immediately. The suspension will be removed after an acceptable cost report has been submitted, reviewed and accepted by HCFA. In no event will substitute cost reports be accepted from those providers using the suspended substitute cost report during the suspension period.

4. Substitute cost reports filed within the sixty (60) day period will maintain their status unless the substitute cost report subsequently proves to be unsatisfactory.

5. The submitting organization will be notified by letter as to the nonacceptance or continuing acceptance of the existing substitute cost reporting system.

6. If the resubmittal of the substitute cost reporting system is found to be unacceptable, the previous acceptance will be revoked. Such revocation will be effective until a new prospective acceptance can be granted. In no event will a new acceptance be retroactive to the date of the prior revocation.

108.3 Guidelines on Format Standards for More Sophisticated Cost Finding Methods.-

A. Double Apportionment

1. Worksheet B - First Allocation

a. The heading for Worksheet B must have a line identifying each page of the print out as "First Allocation" and either "Double Apportionment Accumulative" or "Double Apportionment Nonaccumulative." The same is applicable to Worksheet B- 1 and Worksheet D-1, lines 25 and 26.

b. Each diagonal line, meaning the point of intersection between the general service cost center line and the column for the same cost center, on Worksheet B (i.e., column 4, line 4, column 7, line 7, etc.) should contain the cost allocated back

to itself if it provides service to itself. Therefore, the total cost will only be reflected on line 74 for the First Allocation except when the total cost is a negative amount, the negative amount must be shown on the diagonal line.

c. Under the Double Apportionment Accumulative method of cost finding, column 4a, lines 2 and 3 will be zero since depreciation is allocated and cannot allocate back to itself. Column 4a, line 4 will equal column 4, line 4; lines 5 through 66 and 68 through 73 will equal the addition of columns 1 through 4; line 67 will equal the addition of column 4a, lines 4 through 66; and line 74 will equal the addition of column 4a, lines 67 through 73. The total of column 4a must equal the total of column 1. Under the Double Apportionment Nonaccumulative method of cost finding, column 4a instructions will be the same with the exception that column 4a, line 4 equals the addition of columns 2 through 4.

d. General service cost centers which are negative in column 1 of Worksheet B and remain negative after receiving cost from other general service cost centers must show this negative cost on the diagonal line and lines 67 and 74 so that column 21 will crossfoot. The negative cost is not to be allocated. General service cost centers which are negative in column 1 of Worksheet B and result in a positive cost at the point of allocation should be allocated in the same manner as the other general service cost centers.

e. Under the Double Apportionment Accumulative method of cost finding, Worksheet B, column 21, any general service cost centers' cost will equal the cost the general service cost center allocated to itself, plus the cost received from other general service cost centers after it was allocated. The remaining cost centers' cost will equal the addition of columns 4a through 20. Under the Double Apportionment Nonaccumulative method of cost finding, Worksheet B, column 21, any general service cost centers' cost will equal the addition of columns 2 through 20 minus column 4a. The remaining cost centers' cost will equal the addition of columns 4a through 20.

Any cost center which results in a negative cost must have a parenthesis to indicate it is a negative. Column 21, line 74 must equal column 1, line 74, and column 4a, line 74.

2. Worksheet B-1 - First Allocation

a. Statistics must be shown for all cost centers that receive service.

b. Establish a line below line 75 entitled, "Total Statistics." This is necessary to verify the unit cost multiplier. This cannot be reflected on the diagonal line since a cost center can allocate back to itself.

c. The recommended statistical basis for allocating the cost of the administrative and general cost center is accumulated cost. The statistic is developed by using column 4a of Worksheet B, adding back any restricted grants, gifts, etc., to the appropriate cost center and set cost centers with negative amounts to zero.

d. For the general service cost centers with negative cost, the unit cost multiplier must not be printed, even though the statistics must be printed departmentally and the negative cost must be displayed on line 74.

e. Worksheet B-1, First Allocation must follow Worksheet B, First Allocation when printed.

3. Worksheet B - Second Allocation

a. The heading for Worksheet B must have a line identifying each page of the print out as "Second Allocation" and either "Double Apportionment Accumulative" or "Double Apportionment Nonaccumulative." The same is applicable to Worksheet B- 1 and Worksheet D-1, lines 25 and 26.

b. The amounts for each cost center in column 1 must be transferred from Worksheet B, column 21, First Allocation.

c. Columns 2 and 3 must be blank since depreciation has already been allocated and no cost can be allocated back to it.

d. Column 4a is computed in the same manner as the First Allocation.

e. The cost to be allocated on the diagonal line and the amount on line 74 must be equal.

f. There should be no cost above the line of the general service cost center being allocated since the Second Allocation is done exactly like the Step-Down cost finding method.

g. The general service cost centers with a negative balance on the diagonal line must be shown on an unspecified, nonreimbursable cost center line and on line 74 so that column 21 will crossfoot.

h. The total of column 21 must equal the total of column 1, line 74 and the total of column 4a, line 74.

4. Worksheet B-1 - Second Allocation

a. The format must be identical to the Step-Down method of cost finding.

b. Statistics must be identical to the statistics used in the First Allocation except no statistics must appear above the general service cost center being allocated.

c. Columns 1 and 2 should be blank since the depreciation has been allocated.

d. The recommended statistical basis for allocating the cost of the administrative and general cost center is developed in the same manner as the First Allocation.

e. For the general service cost centers with negative cost the unit cost multiplier must not be printed, even though the statistics must be printed departmentally and the negative cost must be displayed on line 74.

f. Worksheet B-1, Second Allocation, must follow Worksheet B, Second Allocation when printed.

5. Worksheet D-1, Line 25 - First Allocation

a. Column 1 must equal column 2, Worksheet B, First Allocation.

b. Column 2 must equal column 3, Worksheet B, First Allocation.

c. Where capital-related costs have been directly assigned, a column before column 1 must be displayed and titled, "Directly Assigned," showing the directly assigned cost departmentally.

d. Under the Double Apportionment Accumulative cost finding method the cost will be allocated in the same manner as Worksheet B, First Allocation, except for general service cost centers which began with negative cost on Worksheet B, column 1. If the general service cost center is negative at the time it is to be allocated on Worksheet B, First Allocation, then all costs will be shown on the diagonal line and line 25.BB for the First Allocation of Worksheet D-1. However, if the cost center began as a negative amount on Worksheet B and turned positive by the time it was to be allocated, then the cost must be adjusted using the methodology in HCFA Pub. 15-II, chapter 3, section 334. A line 25.AB must be reflected between lines 25.AA and 25.BB showing the amount of the adjustment so that line 25 will crossfoot.

e. Under the Double Apportionment Nonaccumulative cost finding method there is no "First Allocation" on Worksheet D-1.

f. The total of column 21, line 25.BB must equal the total of column 3, line 25.BB.

6. Worksheet D-1, Line 26 - First Allocation

a. Statistics for line 26 are the same as used for Worksheet B-1, First Allocation for the Double Apportionment Accumulative cost finding method.

b. Establish a line below line 28 titled, "Total Statistics." This is necessary to verify the unit cost multiplier. This cannot be reflected on the diagonal line since a general service cost center can allocate back to itself.

c. Under the Double Apportionment Accumulative cost finding method if the general service cost center is negative at the time it is to be allocated on Worksheet B,

First Allocation, then all the statistics will be shown departmentally. Line 27 will equal the cost to be allocated, and line 28 must not print a unit cost multiplier. If the cost was negative but turned positive on the First Allocation of Worksheet B, the cost on line 27 will be the adjusted cost only.

d. Lines 26.49 and 26.50 should only be used for subproviders on Worksheet D-1. If the corresponding lines on Worksheets B and B-1 were used for additional special care units, then these should be added to line 26.AA for Worksheet D-1 purposes.

7. Worksheet D-1, Line 25 - Second Allocation

a. For the Double Apportionment Accumulative cost finding method, columns 1 and 2 must be blank. Column 3 must equal column 21, Worksheet D-1, line 25, First Allocation.

b. For the Double Apportionment Nonaccumulative cost finding method the cost is transferred from columns 2 and 3 of Worksheet B, First Allocation. (See section 108.3.A.5c for treatment of directly assigned cost.)

c. The diagonal line for each general service cost center must equal the cost on line 25.BB.

d. No cost is allocated to general service cost centers above the general service cost center being allocated.

e. If the general service cost center is negative at the time it is to be allocated on Worksheet B, Second Allocation, then all costs will be shown on the diagonal line, line 25.AB and line 25.BB for the Second Allocation of Worksheet D-1. However, if the cost began as a negative amount on Worksheet B and turned positive by the time it was to be allocated, then the cost must be adjusted using the methodology in HCFA Pub. 15-II, chapter 3, section 334. A line 25.AB must be reflected between lines 25.AA and 25.BB showing the amount of the adjustment so that line 25 will crossfoot.

8. Worksheet D-1, Line 26 - Second Allocation

a. Total statistics will be reflected on the diagonal line and no statistics will be reflected for general service cost centers above the general service cost center being allocated.

b. Statistics will be the same as those used on the Second Allocation of Worksheet B-1.

c. The treatment of general service cost centers with a negative balance, or negative turned positive, will be the same as the First Allocation of Worksheet D-1, line 26 with the exception of 8a., above.

B. Multiple Apportionment

1. General Instructions

a. A Multiple Apportionment cost finding method report must have a line in the heading identifying each page of Worksheets B and B-1 and Worksheet D-1, lines 25 and 26 as "First Allocation" or "Second Allocation" or "Third Allocation," etc., as appropriate, and either "Multiple Apportionment Accumulative" or "Multiple Apportionment Nonaccumulative."

b. Multiple Apportionment cost finding method allocates the cost of the general service cost centers in the same manner as the Double Apportionment and follows the same format standards. For example: A user elects five allocations under this method-ology. The allocation and format standards for allocations one through four are identical to the "First Allocation" format standards of Double Apportionment. The "Fifth Allocation" is identical to the Second Allocation described under the Double Apportionment method of cost finding.

C. Matrix

1. Worksheet B

a. The heading for Worksheet B must have a line identifying each page of the print out as Matrix. The same is applicable to Worksheets B-1 and D-1, lines 25 and 26.

b. Under Matrix it is not feasible for a general service cost center to allocate cost back to itself. Therefore, the total cost will only be shown on line 74.

c. No entries should appear in column 4a.

d. General service cost centers, which result in a negative amount after the allocations, must be shown as an unspecified, nonreimbursable cost center line and on line 74 so that column 21 will crossfoot.

e. No costs must be shown in column 21 for the general service cost centers.

f. The total on line 74, column 21 must equal column 1, line 74.

2. Worksheet B-1

a. Statistics must be shown for all cost centers that receive service.

b. The line for the general cost center being allocated must be blank.

c. Line 75 (Unit Cost Multiplier) must be blank.

d. A line must be added below line 75 to show "Total Statistics."

e. Whenever the direct costs on Worksheet A, column 7 have been approved by the fiscal intermediary as an alternative basis for allocating administrative and general, use the direct costs of all cost centers, including depreciation cost centers adding back adjustments for restricted grants, gifts, etc.; and set cost centers with negative amounts to zero.

f. Statistics must be displayed for general service cost centers with negative amounts.

3. Worksheet D-1, Line 25

a. Where capital-related costs have been directly assigned, a column before column 1 must be displayed and titled, "Directly Assigned," showing the directly assigned cost departmentally.

b. Column 1 must be labeled, "Depreciation to be Allocated."

c. Column 2 must be labeled, "Depreciation - Buildings and Fixtures."

d. Column 3 must be labeled, "Depreciation - Movable Equipment."

e. A line 25.2, "Depreciation - Buildings and Fixtures," must be added and the amount to be entered in column 1 is transferred from Worksheet B, column 1, line 2.

f. A line 25.3, "Depreciation - Movable Equipment," must be added and the amount to be entered in column 1 is transferred from Worksheet B, column 1, line 3.

g. Lines 25.49 and 25.50 are to be used for "subproviders" only; special care units must be included on line 25.AA.

h. Under this method, a general service cost center cannot allocate to itself. The general service cost center line must be blank.

i. General service cost centers with a negative balance on Worksheet B must not be allocated, however, the cost must be reflected on line 25.AB for cross-footing purposes. However, if the cost center began as a negative amount on Worksheet B and turned positive by the time it was to be allocated, then the cost must be adjusted using the methodology in HCFA Pub. 15-II, chapter 3, section 334. A line 25.AB must be reflected between lines 25.AA and 25.BB showing the amount of the adjustment so that line 25 will crossfoot.

j. The total of column 3 and the total of column 21 must be equal.

k. No cost can be shown in column 21 for general service cost centers.

4. Worksheet D-1, Line 26

a. Column 1 must be blank.

b. Statistics must be identical to Worksheet B-1 statistics.

c. The line for the general service cost center being allocated must be blank.

d. Line 28 (Unit Cost Multiplier) must be blank.

e. A line must be added below line 28 and titled, "Total Statistics."

f. Statistics must be displayed for general service cost centers with negative amounts.

110. CONDITIONS UNDER WHICH LESS THAN FULL COST REPORT MAY BE FILED

A. No Medicare Utilization.—A provider that has not furnished any covered services to Medicare beneficiaries during the entire cost reporting period need not file a full cost report to comply with program cost reporting requirements. The provider must submit to its intermediary a statement, signed by an authorized provider official, which identifies the reporting period to which the statement applies and states that (1) no covered services were furnished during the reporting period and (2) no claims for Medicare reimbursement will be filed for this reporting period. This statement must be accompanied by a completed certification page of the applicable cost report forms. The proper form and signed statement must be submitted within 30 days following the close of the reporting period.

B. Low Medicare Utilization.—The intermediary may authorize less than a full cost report where a provider has had low utilization of covered services by Medicare beneficiaries in a reporting period and received correspondingly low interim reimbursement payments which, in the aggregate, appear to justify making a final settlement for that period based on less than a normally required full cost report. Based on the intermediary's knowledge of the provider's Medicare utilization and interim payments and the intermediary's conclusion that it can determine the reasonable cost of covered services furnished beneficiaries, the intermediary will advise the provider that less than a full cost report may be filed. Under this situation, the intermediary will require that the provider furnish all of the following information using program forms: (1) page one of the applicable cost report form, (2) the officer certification sheet, (3) the balance sheet, (4) the statement of income and expense and (5) other financial and statistical data the intermediary may deem appropriate depending upon the circumstances in the individual case. However, regardless of low Medicare utilization or the amount of aggregate interim reimbursement, the intermediary may require full cost reporting and auditing if that is necessary to serve the best interests of the program. Providers must submit the forms and data under this alternate procedure within the same time period required for full cost reports.

C. Implementation.--The procedures described in this section are effective only where, prior to the end of the reporting period or filing period for the cost report, the intermediary advises the provider that it may file less than a full cost report and the provider gives assurance that it will timely file such data. These procedures are not applicable to cost reporting periods where both the reporting period and the related filing period have expired, even though a cost report has not yet been filed for such period. If the provider is required to file a full cost report for other Federal programs, e.g., titles XIX and/or V, the provider may be required by the intermediary to also file a full cost report with the Medicare program.

112. FILING OF COST REPORTS BY PROVIDERS OF CHAIN ORGANIZATION OR OTHER GROUP OF PROVIDERS

Each provider in a chain organization or other group of providers, except as noted below, must file a separate, individual cost report (see HIR 405.406(b)). Such organizations are not permitted to file a combined or consolidated cost report under the Medicare program. The only exception under this rule applies to State health department home health agencies with subunits or branches, who are now permitted to file a combined cost report under the 7800 series of provider numbers. "Other group of providers" refers to an informal assembly of providers (hospitals, SNFs, and HHAs) not owned or controlled by a central group or related interest, but who join together to obtain the benefits of centralized cooperative buying, exchange of medical information, etc.

Multiple-facility complex providers (hospitals, hospital-based SNFs, and hospital-based HHAs) will use the cost report designated for this type of facility which will provide adequate cost data. Institutions which have multiple facilities but only one provider number, or one provider number with subprovider numbers for its related cost entities, are required to submit one cost report under that particular provider number together with the subprovider numbers, if any.

The filing of a combined or a consolidated cost report for a chain organization or other group of providers has never been an acceptable practice under the Medicare program. If the intermediary has unknowingly accepted a consolidated report from a chain, the intermediary may reopen the report within the 3-year period following the date of the notice of program reimbursement issued by the intermediary.

114. DISTINCT PART COST REPORTS MUST NOT BE FILED BY FULLY CERTIFIED SNFs

A fully certified SNF provider may not file a cost report claiming Medicare reimbursement as a distinct part provider. (Section 1861(j) of the Medicare law includes in the definition of the term "skilled nursing facility" a distinct part or a separately operating subunit of an institution.) The determination of program reimbursement due an SNF provider for covered extended care services furnished program beneficiaries during the provider's cost reporting period is dependent on whether the entire institution or only a portion of it is the certified provider.

The determination of whether the entire institution or only a portion of it is the certified provider is made by the Office of the Regional Director servicing the facility and can be changed only by that office in accordance with the appropriate regulations and implementing procedures applicable to the certification process. This status is not subject to change or interpretation by the intermediary. (See part I, section 2415.)

115. COST REPORTS FILED UNDER PROTEST

Providers are permitted to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. The provider must include the nonallowable item in the cost report in order to establish an appeal issue, and the disputed item must pertain to the cost reporting period for which the cost report is filed. Retroactive application of any decision from adjudicated issues are governed by section 2435D of the Provider Reimbursement Manual, Part I.

115.1 Provider Disclosure of Protest.--When a provider files a cost report under protest, the disputed item and amount for each issue must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.

115.2 Methods for Establishing Protested Amounts.--The provider may elect either of two methods to establish protested amounts. In both cases, the actual effect on reimbursable cost(s) will be determined after final adjudication of the issue(s).

A. The nonallowable cost report item may be included in the determination of reimbursable cost through the normal cost finding process. If the provider elects this method, the effects of these items will flow into the total reimbursable cost determined on the cost report. The provider must be able to identify the effect the inclusion of the nonallowable items has on Medicare reimbursement.

B. The effect of each nonallowable cost report item may be estimated by applying reasonable methodology which will closely approximate the actual effect of the item as if it had been determined through the normal cost finding process. In addition, the provider must submit, with the cost report, copies of the working papers used to develop the estimated adjustments in order for the intermediary to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues will be shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation.

115.3 Noncompliance With Requirements for Filing Cost Reports Under Protest.- Providers that deliberately include cost, without disclosing the fact, in the provider cost report that is nonreimbursable under the regulations are subject to those provisions concerning suspected fraud or abuse. Where the provider fails to comply with the requirements for filing cost reports under protest as set forth above, such cases will be referred to the HCFA Regional Division of Quality Control.

120 REDUCTION IN PROGAM PAYMENT UNDER SEQUESTRATION

Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), provides for an automatic deficit reduction procedure to be established for Federal fiscal years (FYs) 1986 through 1991. This section outlines the effect of the legislation on Medicare providers and suppliers of services (Medicaid is specifically exempted). There is no effect on deductible and coinsurance amounts payable by beneficiaries.

Each payment amount would be reduced by a specified percentage which could not exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration (reduction of otherwise payable program payment amount pursuant to a Presidential order under Public Law 99-177) takes place. The reduction percentages would be proportionately decreased in any year in which the excess deficit is small enough to permit a smaller reduction.

NOTE: The applicable reduction percentages by FY are as follows.

- o Federal FY 1986 - 1 percent for all services (Part A and Part B) for the period March 1, 1986 through September 30, 1986.
- o Federal FY 1987 - There is no sequestration order for this period.
- o Federal FY 1988 - 2.324 percent as follows:
  - — November 21, 1987 through March 31, 1988 for all Part A inpatient hospital services and all items and services (other than physicians' services) under Part B.
  - — November 21, 1987 through December 31, 1987 with respect to all other Part A services.

A. Medicare Providers and Other Entities Which are Paid in Whole or in Part on a Reasonable Cost Basis.—

1. Where the provider's FY coincides with the Federal FY, multiply the announced reduction percentages as follows:

a. Federal FY 1986 - Multiply the announced reduction percentage by 7/12 (the number of months remaining after February in Federal FY 1986 divided by 12).

b. Federal FY 1988 Multiply the announced reduction percentage for Part A and Part B services as follows:

(1) Part A inpatient hospital services and all items and services (other than physician's services) under Part B by 132/366 (the number of days from November 21, 1987 to March 31, 1988 divided by 366).

(2) All other Part A services (other than inpatient hospital services) by 41/366 (the number of days from November 21, 1987 to December 31, 1987 divided by 366).

2. Where the provider's or other entity's cost reporting period does not coincide with the Federal FY, the requisite reduction is prorated evenly over the months or days in each of the provider's two cost reporting years to which it applies. For example, where a provider's cost reporting period ends June 30, 1986, the 1 percent reduction applies only to the last 4 months of the cost reporting period (March 1, 1986 through June 30, 1986) and to the first 3 months of the FY 1987 cost reporting period (July 1, 1986 through September 30, 1986). Thus, since the reduction of Federal FY 1986 is 1 percent, the reduction to the cost reporting period ended June 30, 1986, is 4/12 (months) or 132/365 (days) of 1 percent and the reduction to the provider's subsequent cost reporting period ended June 30, 1987, is 3/12 (months) or 92/365 (days) of 1 percent (days are used after FY 1986 to prorate the adjustment).

B. Special Instructions for Hospitals Subject to the Prospective Payment System (PPS).--Hospitals subject to the PPS have the option of having their sequestration adjustment (for inpatient hospital services) computed in accordance with subsection A or to be computed on a DRG specific basis as outlined in subsections B.1 and B.2. Compute the sequestration adjustment for hospital inpatient pass through costs and outpatient services in accordance with subsection A. If the hospital elects to have its sequestration adjustment computed on a DRG specific basis, it must furnish to its fiscal intermediary (FI) the detailed documentation necessary to enable the FI to verify the sequestration amount shown on the cost report.

1. Hospital's cost reporting period coincides with the Federal FY.

a. Compute the sequestration adjustment for the period (for hospital inpatient services paid under PPS, including additional payments for high percentage of ESRD beneficiary discharges) on Form HCFA 2552-85, Worksheet E, Part A, as follows:

The sequestration adjustment is to be applied to actual discharges which occurred during the period for which the cost report is filed. The amount to be adjusted is (for discharges which occurred during that portion of the cost reporting period) the sum of line 1A (DRG other than outlier payments), line 1B (outlier payments) line 6A (disproportionate share) and line 7A (additional payment for high percentage of ESRD beneficiary discharges), minus the sum of line 10 (primary payor amounts applicable to program beneficiaries discharged during the applicable period of the cost report), line 12A (deductibles billed to program beneficiaries discharged during the applicable period of the cost report), and line 12B (coinsurance billed to program beneficiaries discharged during the applicable period of the cost report), times the announced percentage.

b. The sequestration adjustment computed in accordance with subsection A.1 for the PPS hospital inpatient services reimbursed on a cost basis is to be applied to the Medicare reasonable cost computed on HCFA 2552-85, Worksheet E, Part A, as follows:

The amount to be adjusted is the sum of line 2 (routine service pass-through cost), line 3 (ancillary service pass-through cost), line 4 (net kidney acquisition cost), line 5 (cost of teaching physicians), line 6 (indirect medical education adjustment), line 7B (outside suppliers), line 8 (return on equity capital), line 13 (bad debts for deductibles and coinsurance), line 15 (recovery of unreimbursed cost under the lesser of reasonable cost or customary charges), line 17 (amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets), minus line 16 (recovery of excess depreciation resulting from provider termination or a decrease in program utilization).

2. Hospital's cost reporting period does not coincide with the Federal FY.

The requisite reduction is applied in accordance with the formula outlined in subsections B.1.a and b as follows (see subsection A.2 with respect to using days to prorate the sequestration adjustment after Fy 1986):

a. The sequestration adjustment based upon discharges is applied to the discharges occurring in the months or days of the provider's two cost reporting periods to which it is applicable, plus

b. The cost based sequestration adjustment portion is prorated evenly over the months or days of the two cost reporting periods to which it is applicable.

C. Computing on a Reasonable Cost Basis.—In preparing its cost report at the end of the cost reporting period, the provider or other entity applies the appropriate sequestration adjustment (as outlined in subsection A) to reduce the total net costs reimbursable to the provider (or other entity) as part of the process of arriving at the "balance due the provider/program." Such reduction is applied to net reimbursement after subtracting deductible and coinsurance amounts.

The adjustment is made after determining the amount of total Medicare payment due to the provider or other entity for covered services furnished to eligible beneficiaries during the cost reporting period. The line under column 6 indicated on the following chart is divided into three lines (e.g., Form HCFA 2552-85, Worksheet E, Part A, line 18 becomes lines 18A, 18B and 18C). The first of these lines (e.g., line 18A) is computed by following the instructions that existed for the line (e.g., line 18) before applying these instructions. The second line (e.g., line 18B) is the sequestration amount, and is computed by applying the applicable percentage to the amount of the preceding line (e.g., line 18A). The third line (e.g., line 18C) is the amount due the provider after applying the sequestration adjustment, and is computed by subtracting the amount on the second line from the amount on the first line (e.g., line 18A minus line 18B). All lines following the adjusted amount due the provider (e.g., line 18C) are computed following the existing instructions as if the amount on the affected line (e.g., line 18) were the amount determined as due the provider after the sequestration adjustment (e.g., line 18C).

Provider Type	Form HCFA	Worksheet/ Schedule	Part	Columns(s)	Line
Independent Organ Procurement Agency and Histocompatability Laboratory	216	D	-	1 & 2	7
Rural Health Clinic	222	3	B	-	12
Independent Renal Dialysis Facility	265	D	-	-	9

Provider Type	Form HCFA	Worksheet/ Schedule	Part	Columns(s)	Line
Home Health Agency	1728	D	II	1, 2 & 3	32
Outpatient Physical Therapy and Speech Pathology Provider and Comprehensive Outpatient Rehabilitation Facility	2088	C	I	-	15
Skilled Nursing Facility-Cost Reporting Periods Beginning Prior to 1/1/86	2552-81	E	III	8 & 9	69
Skilled Nursing Facility-Cost Reporting Beginning on or after 1/1/86	2540-86	E-Part I E-Part II H-6 H-6	A B A B	1 1 1 2	34 25 22 22
Skilled Nursing Facility-Cost Reporting Periods Beginning on or after 10/1/86-for providers electing prospective payment	2540S-87	E E	A B	1 1	15 14
Skilled Nursing Facility Based Home Health Agency	2552K-81	H-6	II	1, 2 & 3	32
Hospital or Subprovider Under PPS - Part A Services	2552-85	E	A	-	18
Hospital, Subprovider, Hospital-Based Skilled Nursing Facility Services - Part B	2552-85	E	B	-	33
Hospital-Swing Bed	2552-85-E-2	E-2	-	1 & 2	22
Hospital or Subprovider-TEFRA Reimbursement	2552-85-E-3	E-3	I	-	20

Provider Type	Form HCFA	Worksheet/ Schedule	Part	Columns(s)	Line
Hospital, Subprovider, Hospital-Based Skilled Nursing Facility-Cost Reimbursement-Part A	2552-85-E-3	E-3	II	-	36
Hospital-Based Home Health Agency	2552-85-H	H-6	II	1 & 2	26
Hospital-Based Comprehensive Outpatient Rehabilitation Facility	2552-85-J	J-3	-	-	17

D. Proprietary Providers.--For proprietary providers, the beginning equity for the following cost reporting period must be computed by reducing the ending equity of the current period by the amount of the sequestration adjustment as well as any other applicable adjustment to ending equity.

IM 198. COST REPORTING--GENERAL

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) was enacted. Section 9107 of the Act explicitly provided for changes in the level of payments for return on equity capital for proprietary providers. These provisions are self implementing.

A. Hospitals (Inpatient Services).--Section 9107 requires that payments for a return on equity capital applicable to hospital inpatient services be phased down and eliminated as follows:

1. For cost reporting periods beginning during fiscal year 1987 (beginning on or after October 1, 1986, and before October 1, 1987), the rate of return will be 75 percent of the average of the rates of interest for each month any part of which is included in the period, on special issues of debt obligation issued for purchase by the Medicare Part A Trust Fund.

2. For cost reporting periods beginning during fiscal year 1988 (beginning on or after October 1, 1987, and before October 1, 1988), the rate of return will be 50 percent of the average of the rates of interest for each month any part of which is included in the period, on special issues of debt obligation issued for purchase by the Medicare Part A Trust Fund.

3. For cost reporting periods beginning during fiscal year 1989 (beginning on or after October 1, 1988, and before October 1, 1989), the rate of return will be 25 percent of the average of the rates of interest for each month any part of which is included in the period, on special issues of debt obligation issued for purchase by the Medicare Part A Trust Fund.

4. For cost reporting periods beginning on or after October 1, 1989, the rate of return will be 0 percent.

B. Other Services.--With respect to other provider services (including hospital outpatient services) for which regulations may provide for payment of a return on equity, the Act requires the rate of return to be reduced from one and one-half to one times the average rates of interest for each month any part of which is included in the period, on special issues of public debt obligations issued for purchase by the Medicare Part A Trust Fund. This provision is effective for cost reporting periods beginning on or after October 1, 1985.

Subsequently, on October 21, 1986, the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) was enacted. Section 9303 of the Act provides that all capital related costs of inpatient hospital services (including return on equity capital), of subsection (d) hospitals (hospitals subject to the prospective payment system) are to be reduced. (Note: Sole community hospitals are exempt from this reduction). A final regulation with comment period implementing this provision was published in the Federal Register on November 24, 1986 (Vol. 51, No. 226, pages 42229 -42235).

The amount of payment with respect to capital related costs shall be reduced by the following percentages (after taking the appropriate reductions to return on equity):

1. 3.5 percent for payments atttributable to portions of cost reporting periods occurring during Federal fiscal year 1987 (October 1, 1986, through September 30, 1987).

2. 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during Federal fiscal year 1988 (October 1, 1987, through September 30, 1988).

3. 10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989 (October 1, 1988, through September 30, 1989).

C. Interim Payments.--Intermediaries are being instructed to incorporate these reductions into current interim payment rates. Retroactive adjustments or, if appropriate, a reduction lower than would otherwise be necessary may be made to compensate for the retroactive portion of the current cost reporting period. These adjustments or larger reductions are necessary to account for the effective dates mandated by the statute.

D. Final Settlements.--All affected cost report settlements of providers must reflect these reductions inasmuch as the equity capital changes were effective, in part, retroactive to cost reporting periods beginning on or after October 1, 1985.

IM 199. COST REPORTING--GENERAL

Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman), provides for an automatic deficit reduction procedure to be established for Federal fiscal years (FYs) 1986 through 1991, when the deficit would reach zero. This interim manual instruction outlines the effect of the legislation on Medicare providers and suppliers of services (Medicaid is specifically exempted) which are paid in whole or in part on a reasonable cost basis. There is no effect on deductible and coinsurance amounts payable by beneficiaries.

A. With regard to the Medicare program, each payment amount would be reduced by a specified percentage, which could not exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration (reduction of otherwise payable program payment amount pursuant to a Presidential order under P.L. 99-177) takes place. The reduction percentages would be proportionately decreased in any year in which the excess deficit is small enough to permit a smaller reduction. Due to the effective period of the initial year of implementation, the announced FY 1986 reduction percentage would be multiplied by 7/12 (the number of months remaining after February in Federal FY 1986 divided by 12).

B. Where the provider's or other entity's cost reporting period does not coincide with the Federal FY, the requisite reduction would be prorated evenly over the months of the provider's two cost reporting years to which it is applicable. For example, where a provider's cost reporting period ends June 30, 1986, the 1 percent reduction would be applicable only to the last 4 months of the cost reporting period (March 1, 1986 through June 30, 1986) and to the first 3 months of the FY 1987 cost reporting period (July 1, 1986 through September 30, 1986). Thus, if the reduction for Federal FY 1986 is 1 percent, the reduction to the cost reporting period ended June 30, 1986, would be 4/12 of 1 percent and the reduction to the provider's subsequent cost reporting period ended June 30, 1987, would be 3/12 of 1 percent for the portion of the period July 1, 1986 through September 30, 1986, plus 9/12 of the sequestration percentage subsequently determined for Federal FY 1987.

C. In preparing its cost report at the end of the cost reporting period, the provider or other entity would apply the appropriate sequestration percentage (as outlined above) to reduce the total net costs reimbursable to the provider (or other entity) as part of the process of arriving at the "balance due the provider/program." Such reduction is applied to net reimbursement after subtracting deductible and coinsurance amounts.

The adjustment is made after determining the amount of total Medicare payment due to the provider or other entity for covered services furnished to eligible beneficiaries during the cost reporting period. The line under column 6 indicated on the following chart is divided into three lines (e.g., Form HCFA-2552-85, Worksheet E, Part A, line 18 will become lines 18A, 18B, and 18C). The first of these lines (e.g., line 18A) is computed by following the instructions that existed for the line (e.g., line 18) before applying these instructions. The second line (e.g., line 18B) is the sequestration amount, and is computed by applying the applicable percentage to the amount on the preceding line (e.g., line 18A). The third line (e.g., line 18C) is the amount due the provider after applying the sequestration adjustment, and is computed by subtracting the amount on the second line from the amount on the first line (e.g., line 18A minus line 18B). All lines following the adjusted amount due the provider (e.g., line 18C) are computed following the existing instructions as if the amount on the affected line (e.g., line 18) were the amount determined as due the provider after the sequestration adjustment (e.g., line 18C).

Provider Type	Form HCFA	Worksheet/ Schedule	Part	Column(s)	Line
Independent Organ Procurement Agency and Histocompatability Laboratory	216	D	-	1 & 2	7
Rural Health Clinic	222	3	B	-	12
Independent Renal Dialysis Facility	265	D	-	-	9
Home Health Agency	1728	D	II	1, 2 & 3	32
Outpatient Physical Therapy and Speech Pathology Provider and Comprehensive Outpatient Rehabilitation Facility	2088	C	I	-	15
Skilled Nursing Facility	2552-81	E	III	8 & 9	69
Skilled Nursing Facility Based Home Health Agency	2552K-81	H-6	II	1, 2 & 3	32
Hospital or Subprovider Under PPS - Part A Services	2552-85	E	A	-	18
Hospital, Subprovider, Hospital-Based Skilled Nursing Facility Services - Part B	2552-85	E	B	-	33
Hospital-Swing Bed	2552-85-E-2	E-2	-	1 & 2	22
Hospital or Subprovider-TEFRA Reimbursement	2552-85-E-3	E-3	I	-	20
Hospital, Subprovider, Hospital-Based Skilled Nursing Facility-Cost Reimbursement-Part A	2552-85-E-3	E-3	II	-	36
Hospital-Based Home Health Agency	2552-85-H	H-6	II	1 & 2	26

Provider Type	Form HCFA	Worksheet/ Schedule	Part	Column(s)	Line
Hospital-Based Comprehensive Outpatient Rehabilitation Facility	2552-85-J	J-3	-	-	17

D. For proprietary providers, the beginning equity for the following cost reporting period must be computed by reducing the ending equity of the current period by the amount of the sequestration adjustment as well as any other applicable adjustment to ending equity.